HOME DELIVERED MEAL PROGRAM:

HOME DELIVERED MEAL WAITING LISTS

Home Delivered Meals are delivered to seniors age 60 or older who are homebound. The Area Agency on Aging contracts with twenty one different Nutrition Projects to provide service in different geographical areas covering all of Los Angeles County. The Nutrition Projects want to serve all seniors who meet the criteria. However, some projects have more requests for service than they can fill because of staff, equipment, and funding constraints.

All agencies fill out a Determination of Need Form when the client requests home delivered meals. If there is no waiting list, meals are started immediately. An in-home assessment is done within ten working days to verify the need for the meals. The client is reassessed quarterly to verify continued need for the meals. If the client is no longer homebound, meals are discontinued; the client is encouraged to come to the nearest senior center for lunch.

Some agencies have waiting lists. They use the Determination of Need Form to prioritize starting new clients on the service when spots become available. Those people most at risk are started first. The projects periodically check people on the waiting lists to see if they still wish to receive meals when space becomes available. Ideally, seniors are started as soon as possible.

Typically, the need for meals is greatest right after a senior is discharged from the hospital. Some people recover, and no longer need meals. Others are on the program for long periods. The Area Agency on Aging philosophy is to serve those at greatest need, and to continually update the home delivered need lists to make sure that we are serving seniors who need home delivered meals.

CONGREGATE MEALS & HOME-DELIVERED MEALS

PURPOSE

CONGREGATE MEALS are designed to maintain or improve the physical and social well-being of mobile older adults through appropriate nutrition services in a group setting

HOME-DELIVERED MEALS are provided to maintain or improve the physical and social well-being of homebound older adults through nutrition services

DESCRIPTION OF SERVICES

CONGREGATE MEALS

- Congregate meals are served 5 days a week in a convenient location, accessible to seniors
- Mobile seniors are encouraged to attend the same nutrition site on a daily basis
- Monthly calendar of daily menu selection provided to seniors
- All meals prepared meet USDA dietary guidelines

HOME DELIVERED MEALS

- Homebound seniors are provided 5 to 7 nutritionally balanced, hot or frozen meals delivered to their homes
- Storing and heating instructions are provided for every meal delivered

COST OF MEALS TO SENIORS

The congregate meal and home delivered meal programs do not require seniors to pay for meals, however, donations ranging between $1 - $2 per meal are appreciated

PROVIDERS

- There are currently more than 100 congregate meal sites throughout Los Angeles County (excluding L. A. City)
- There are 24 contracted service providers, the majority operating both congregate meal sites and home-delivered meals

BENEFITS

- In FY 1997-98, 1,047,981 meals were delivered to 262,659 homebound seniors and 1,699,160 congregate meals were served to older adults throughout the County
- Home-delivered meals act as a form of outreach to homebound seniors
- Congregate meal sites are commonly located at senior centers or community centers where there are additional opportunities for seniors to participate in social and/or recreational activities
- Congregate meal sites provide initial nutrition screenings to older adults, those at nutritional risk are visited by registered dietitians from the ENHANCE program

CUSTOMER SATISFACTION

All congregate and home-delivered meals conduct on-going customer satisfaction surveys. Surveys result in menu changes and improvements in these services to older adults

FUNDING

Older Americans Act Title IIIC1 & C2; additional funds are generated from client donations and agency contributions

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INTAKE SCREEN: NEED FOR HDMS

Directions: Use to determine level of need for HDMS. Do a screen for all clients.

CLIENT:_____ **Phone:** _____
OTHER CONTACT:_____ **Phone:** _____
RELATIONSHIP TO CLIENT:_____
REASON CLIENT IS HOMEBOUND:_____

1. Client is 60 to 74 years old 1
   Client is 75 to 84 years old 2
   Client is 85+ years old 3

2. Client is bed bound 3
   Client is in wheelchair 2
   Client uses walker/walking aids 1

3. Client has recently been discharged from the hospital (2 pts.) 2
   Hospital_____ Major Problems (1 pt. each up to 3 pts.)
   Date of Discharge_____ _____
   _____ _____
   _____ Pts.____

4. Clients lives alone without help 2
   Client lives alone with help 4 hours/day or less 1
   Client lives with working family member 1
   Client lives with disabled spouse, disabled child 2

5. Client is on SSI or MediCal 2

6. Client is member of minority group 1
   Circle group: African-American Hispanic American Indian Asian-Pacific Islander

7. Other risk factors (1 pt. each: 3 pts. max.) or comments. Risk factors can include lack of money for food, mental illness, short term memory loss, etc.

   _____ Pts. ____

   _____ ____

   _____ ____

TOTAL SCORE: ____

In case of waiting lists, clients with greatest need (highest score) are served first.

Does client own or have access to a car? _____ Is client able to drive?_____

Completed by: _____

Date: _____

Subject: Enrolling/Starting Clients in the HDM Program	Page: 1 of 1
Issued by: AAA	Date: October 2001

POLICY: Clients will be enrolled in the Home Delivered Meal (HDM) Program and meals started as promptly as possible. If there is a waiting list, the client with the greatest need will be served first.

PROCEDURES:

A. **Start Up**

1. When a client is referred, complete the Client Intake form and the Intake Screen: Need for HDMS form.
2. Determine if the client is qualified for the HDM program. The client must be 60 years old and homebound. Disabled persons younger than 60 are not eligible for the program.
3. Tell the client or the referring party if and when the client will start meals.
4. If necessary, place the client on a waiting list.

B. **Referrals to Food and Nutrition Management**

1. Refer the client to Food and Nutrition Management if the client scores 9 points or higher on the National Nutrition Screen, part of the Client Intake form.
2. Refer the client to Food and Nutrition Management regardless of score if the client is a diabetic.

C. **Starting Meals**

1. Start meals as soon as possible, but at least within twenty-four to forty-eight hours after referral, providing space is available.
2. Complete the In-Home Assessment within 10 working days after starting the client on HDMs.

D. **Waiting Lists**

1. If waiting lists exist, place client on a waiting list for a specific meal route.
2. When an opening occurs, start the client with the greatest need as determined by the Intake Screen: Need For HDMS form, not the client who has been on the list the longest time.
3. Call all clients on the HDM waiting lists each month to see if they still wish to receive meals.
4. Periodically review and adjust meal routes to try to eliminate waiting lists and to equalize route length.

E. Starting the client on the HDM program

1. With the first meal delivery, the HDM Driver will give the HDM client basic information about the meal program, including:
   a. Instructions for handling the meals safely
   b. How to call the program to report problems, cancel meals, etc.
   c. Donation procedures
2. The driver will assist the client to fill out two forms:
   a. Client Agreement
   b. MD Certification for HDMs
3. The driver will assist the client in filling out the forms if necessary.
4. The driver will pick up the forms on the next visit and give them to the HDM Coordinator.

Subject: In-Home Assessment for HDM Clients	Page: 1 of 1
Issued by: AAA	Date: October 2001

POLICY: The In-Home Assessment for HDM Clients will be completed within ten (10) working days after the client has been started on the HDM program.

PROCEDURES:

A. Conducting the Assessment

1. The In-Home Assessment will be conducted by the Home Delivered Meal Coordinator or by trained personnel, such as the Case Managers.
2. The assessment will be completed within ten (10) working days after the client has been started on the HDM program.
3. The Assessor will check to make sure the following forms have been completed or will complete them during the visit:
   a. MD Certification for HDMs
   b. Client Agreement
4. The Assessor will complete the In-Home Assessment form.

B. Referrals

1. After completing the assessment, the Assessor will refer the client to other services such as Care Management, Food Bank, Genesis, etc.
2. The Assessor will note referrals in the Client's chart.

HDM: RECORD KEEPING

Subject: Follow ups for HDM Clients	Page: 1 of 1
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POLICY: The HDM Coordinator will periodically update clients' status and need for HDMs.

PROCEDURES:

A. **Reports from HDM Drivers**

1. HDM Drivers will fill out the HDM Driver Report form and give it to the HDM Coordinator if they notice the following:
   a. A change in condition (eg a patient suddenly bed-bound)
   b. Smelly or unkempt home
   c. Evidence that meals have not been comsumed.
2. The HDM Coordinator will be responsible for helping to solve the problem noted, or for referring the client to another agency to help solve the client's problems.
3. The HDM Coordinator will note action taken in the client's chart.

B. **Reports from other Agencies**

1. The HDM Coordinator will read and file in clients' charts reports about clients sent by other agencies such as Food and Nutrition Management (Enhance), Care Management, etc.
2. The HDM Coordinator will be responsible for reviewing other findings, and adapting agency services if possible and necessary.
3. The HDM Coordinator will note any action taken in the client's chart.

C. **Quarterly Updates**

1. The HDM Coordinator or a person designated by the HDM Coordinator will call clients at three and nine months after they have been enrolled in the HDM program to determine if the clients still need HDMs.
2. The caller will fill out the HDM Client Update Form.
3. The HDM Coordinator or a trained person designated by the HDM will conduct in-home client visits at six months and one year after clients still need HDMs.
4. If there is no change in the client's condition, the visitor will fill out the HDM Client Update Form.
5. If there is a major change in the client's condition, the visitor will fill out a new Intake Screen: Need for HDMs and a new In Home Assessment.
6. The HDM Coordinator will make additional referrals as necessary.